

region. Figures for COPD prevalence vary from 3% among Finnish women to 57% of Italians older than 45 years. Epidemiological research indicates that COPD is an underdiagnosed and undertreated disease. The literature search for health economic articles generated 181 matching articles of which 26 analyses considered European health economics. Cost-of-illness and cost-effectiveness studies were mainly used as analytic strategies. Cost-of-illness studies indicate that hospital care and medication are the major cost drivers in the treatment of COPD. Annual direct expenditures per patient in Europe range from €530 in France to €3239 in Spain. In cost-effectiveness analyses, no uniformity in definition of outcomes exist. Disease severity was not always delineated, and the length of time horizon examined varied from 4 months to 2.5 years. **CONCLUSION:** Improvement of diagnostic techniques and enforcement of professionalism in diagnostic procedures as well as a uniform definition of COPD have to be accomplished in order to obtain reliable epidemiological data and to ensure the quality of health economics studies. These data could be used to carry out health economics studies according to each country's guidelines or to develop them where no respective guidelines exist.

PMD23

IDENTIFICATION OF UNIT COSTS IN RHEUMATOID ARTHRITIS—RESEARCH APPROACH AND RESULTS

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OBJECTIVE: To elaborate a useful level of detail according to measurement and valuation of costs associated with rheumatoid arthritis. **METHODS:** Unit costs—comprehended as multiplicative part of costs as product of amount and price—have a substantial impact on health economic evaluations. Performing an intensive Internet research we assessed country-specific unit costs for the 10 cost domains doctor visit, medication, diagnostic procedures, monitoring, hospitalization, rehabilitation, personal help, stoppage, traveling and other treatments. The most differentiated cost domains were rheumatic medications (65 cost items) and monitoring (25 cost items). We reported the type of cost item, country, total costs of one unit, name of data source, date of data, homepage address, date of review, calculation assumption and calculation method. The evaluation was performed for Australia, Canada, France, Germany, and Great Britain. All unit costs were given in national currency as well as US\$ for comparative purpose. **RESULTS:** Significant differences in values of unit costs were identified with the Internet research. The country-specific values of comparative unit costs differed a lot. England and Australia show high differences of unit cost values per type of doctor visit. All five countries have high variances within the different diagnostic procedures, the kind of personal help and the type of traveling. The most differentiated references for

the evaluation of medication costs were found in Germany. **CONCLUSION:** In general the identification of unit costs therefore has to adapt the specific payment systems of health care. It is non-permissible to transfer country-specific results to other countries. Because the amount of unit costs differs a lot, each health economic study report has to explain the used calculation approach. Otherwise the user is unable to prove the robustness of data. Additionally the performance of sensitivity analysis is aggravated.

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FIRST EXPERIENCES WITH THE CONDUCTION OF RAPID HEALTH ECONOMIC HEALTH TECHNOLOGY ASSESSMENTS

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OBJECTIVES: The German Agency for Health Technology Assessment (DAHTA) at the German Institute for Medical Documentation and Information (DIMDI) commissions research projects for Health Technology Assessment (HTA). The authors were engaged to develop methodological guidelines for the conduction of rapid health economic HTA and simultaneously to conduct a rapid health economic HTA to assess the cost-effectiveness of Quantitative Ultrasound (QUS) as a technique for screening and diagnosing osteoporosis. This abstract describes first experiences of the feasibility of the developed methodological guidelines made by the assessment of cost-effectiveness of QUS. **METHODS:** Methodological recommendations for rapid health economic HTA were given to the following structural elements: study question, background information, perspective, decision analysis, searching and evaluation of information, discussion, conclusion, quality assurance and dissemination. Based on this recommendations we conducted the assessment of the cost-effectiveness of QUS. A detailed description of the guidelines as well as of the results of the assessment of cost-effectiveness of QUS are given elsewhere. **RESULTS:** Even though the methodological guidelines turned out to be a proper instrument for the conduction of rapid health economic HTA, two crucial points should be pointed out: 1) study question should be formulated precisely. We restricted the original study question commissioned by DAHTA regarding to the study population, number of compared technologies and clinical outcome parameters; 2) methodological recommendations clearly support the conduction of decision modeling. In the case of QUS strong limitations could be found, mainly due to the missing of effectiveness data. **CONCLUSION:** The conduction of a rapid health economic HTA demands careful considerations. In cooperation with the potential addressee the study question should be focused. In some cases, especially in the case a decision analysis is demanded rapid health economic